

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 170 SS=C	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The following citations represent the findings of a Health Resurvey and Complaint Investigation #84159.</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on interviews, the facility failed provide the residents of the facility with mail service 6 days a week as required.</p> <p>Findings included:</p> <p>On 2/26/15 at 3:30 PM, resident #34 reported he/she was unsure if the facility delivered mail on Saturdays. He/She had not received any mail on Saturday.</p> <p>On 3/4/15 at 11:01 AM, licensed nursing staff N reported the activity director usually received mail throughout the week, but not on Saturday. Staff N added that he/she never thought about getting the mail over the weekend for the residents.</p> <p>On 3/4/15 at 11:50 AM, administrative nursing staff A confirmed the facility delivered the mail to the residents Monday through Friday only.</p> <p>On 3/4/15 at 12:12 PM, administrative nursing staff A reported, after talking with the facility staff, in the past the residents used to receive the mail on Saturday. The facility had quit providing the</p>	F 170			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 170	Continued From page 1 mail service on Saturdays, but was unable to explain any reasoning.  The facility failed provide the residents of the facility with mail service 6 days a week as required.	F 170			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on observation and interview, the facility failed provide effective maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable environment for residents, which included, 1 of 2 resident hallways, beauty shop, east whirlpool room, the sun room, and in front of the nurses room.  Findings included:  - Environmental tour on 3/4/15 at 10:00 AM, revealed findings below:  The beauty shop on the West hall;  1.) One hair brush with no name and visible hairs in the bristles.  2.) Two hair dryers had a white colored build-up on the filters.  3.) Six drawers with hair clippings in the bottoms.  4.) One drawer had 2 of the razors had hair in the	F 253			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	<p>Continued From page 2 blades and were dirty.</p> <p>5.) The chair had an approximate 6 inch tear at the seam, with visible hair clippings and the inner foam exposed.</p> <p>6.) The sink's drain basket held gray debris build-up and loose hairs.</p> <p>East hallway, Resident rooms:</p> <p>1.) One room contained a glass window pane cracked with approximately 1 inch diameter center hole. Three cracks radiated outward, approximately 3 inches, 5 inches and 6 inches in length.</p> <p>2.) One room contained floor tiles in the bathroom, with separation between the tiles.</p> <p>3.) Two rooms contained blinds and window sills with debris and dust build-up.</p> <p>4.) Two rooms contained repaired walls which lacked paint over the repaired areas.</p> <p>5.) One room had cracked floor tiles at the entrance of the room.</p> <p>6.) One room contained a personal comb on the shelf above the sink without a resident name on it and with visible hair in the teeth.</p> <p>The East Whirlpool room:</p> <p>1.) Three hair pics which lacked the resident's name and held several different shades of visible hair in the teeth.</p> <p>2.) One comb which lacked the resident's name</p>	F 253			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	<p>Continued From page 3</p> <p>and had several different shades of visible hair in the teeth.</p> <p>3.) One brush which lacked the resident's name and held several different shades of visible hair in the bristle's.</p> <p>The Sun room:</p> <p>1.) Eight wheelchair pedals rested on the floor in the corner of the room.</p> <p>On 3/4/15 at 10:15 AM, maintenance staff U, stated the maintenance staff does the painting and repairing of the walls. The staff came on 2/26/15 and fixed the resident room walls, but had not been able to come back to paint the walls due to doing another maintenance project at another building. Maintenance staff R took care of notifying staff U, when there was something that needed fixed. Staff R faxed the concerns weekly to Staff U. He/She did not know how the facility monitored the condition of the rooms and what needed fixed in the facility, as Staff R was in charge of that. He/she expected that Staff R monitored the condition to see if anything needed fixed monthly.</p> <p>On 3/4/15 at 4:07 PM, Maintenance staff R, stated he/she and the housekeepers monitored the condition of the facility periodically. Usually the staff will let Staff R know when something was broken and needed fixed. Staff R, also stated that he/she used to use a check list weekly or monthly to check the condition of the building and the residents rooms, but it was not working out well, so that system was stopped. At this time Staff R lacked any documentation of what the housekeeping staff looked at or if anything was being monitored for repairs/extra cleaning. The</p>	F 253			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253	Continued From page 4 broken window had been broken for a couple of years. Staff R reported it when it was first noticed. The staff figured it was caused by a BB gun because the hole was so small. Now from the weather over the years the window had cracked more and the hole had grown to an 1 inch diameter.  The facility failed to provide the necessary housekeeping and maintenance services to maintain a sanitary, comfortable environment for the residents of this facility.	F 253			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This Requirement is not met as evidenced by: The facility reported a census of 27 residents with 18 selected for sample review. Based on	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 5</p> <p>observation, interview, and record review, the facility failed to review and revise the resident's plan of care for 1 resident (# 32) to prevent repeated falls. Additionally, the facility failed to invite the family member for resident (# 31) to the initial comprehensive care plan meeting.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident # 32's admission MDS (minimum data set) assessment, dated 2/3/15, identified the resident with severely impaired cognition, long and short term memory impairment, and with modified impairment for decision making skills. The assessment identified the resident required extensive assistance of 1 staff for ADL's (activities of daily living) of transfers and walking. Additionally, the resident had unsteady balance, no ROM (range of motion) impairment, used a walker, and experienced a fall history with 1 fall since admission.</li> </ul> <p>The 2/3/15 Care Area Assessment for falls identified the resident at risk for falls related to a fall at home, and a lack of safety awareness.</p> <p>The fall risk assessments, identified the resident at high risk for falls on 2/3/15 with a score of 18, and on 2/1/15 with a score of 20. The assessment indicated a score of 10 or greater indicated a high risk for falls.</p> <p>The resident's 2/9/15 care plan instructed staff:</p> <ol style="list-style-type: none"> <li>1. Ensure the use of walker when walking.</li> <li>2. Ensure shoes or non-skid socks on.</li> <li>3. Supervision when up and about and usually required one assist with all cares and cues when</li> </ol>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 6 walking.</p> <p>4. Monitor for any changes in balance.</p> <p>5. Keep room free of clutter.</p> <p>6. On 2/10/15, the latest intervention included PT (physical therapy) to evaluate the resident for wheeled walker safety. The staff failed to review and revise the residents care plan timely, as the fall occurred on 2/1/15. The intervention was added 9 days later. Additionally, the staff failed to implement the intervention, timely, as the resident's PT evaluation did not occur until 2/20/15, and failed to obtain results of the evaluation, until 3/3/15.</p> <p>Review of nursing notes, for a fall, which occurred on 2/1/15, included documentation at 11:10 AM, that the resident fell in the commons area. The documentation further identified the staff observed the resident had the rolling walker too far out in front of the him/her, which caused the resident to sit down on his/her bottom. The documentation further noted a request from the physician for a PT evaluation for safety with the use of the rolling walker, as the intervention, to prevent another fall.</p> <p>On 3/2/15 at 11:15 AM, direct care staff E, used a gait belt on the resident and a 4 wheel rolling walker, to assist the resident. Staff E reported the resident more confused at times than others and needed cueing for ADL's, with some assistance.</p> <p>On 3/2/15 at 9:00 PM, the resident rested in bed, with a ¼ rail on 1 side of the bed in the raised position, and the rolling walker at the bedside.</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 7</p> <p>On 3/3/15 at 7:15 AM, the resident ambulated with the use of a rolling walker, a gait belt and staff assistance, to the dining table.</p> <p>On 3/3/15 at 2:01 PM, direct care staff F reported he/she lacked awareness of the resident experiencing any falls, and/or any changes in the resident's plan of care.</p> <p>Licensed nursing staff C reported, on 3/3/15 at 2:56 PM, the staff failed to develop an immediate intervention, to prevent another fall, from 2/1/15 to 2/20/15, (19 days).</p> <p>The facility failed to review and revise the resident's plan of care to instruct staff in the implementation of new interventions in a timely manner to prevent repeated falls, after the resident experienced a fall.</p> <p>- Resident # 31's admission MDS (minimum data set) assessment, dated 2/3/15, identified the resident with severely impaired cognition, long and short term memory impairment, and with modified impairment for decision making skills.</p> <p>Review of the resident's care plan identified the staff conducted a comprehensive care plan on 2/9/15.</p> <p>Interview, on 2/26/15 at 9:03 AM, with the resident's family member indicated the facility had not invited the family to attend the resident's care plan meeting.</p> <p>On 3/3/15 at 4:00 PM, social services D, reported the facility have a sign-in form for care plan meetings, which all attendees sign. The staff, after reviewing the resident's clinical record,</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 8</p> <p>indicated the facility failed to use the document when the resident's initial care plan meeting was held.</p> <p>On 3/3/15 at 4:00 PM, medical records staff G, reported after checking the letters of invitation sent to families, confirmed the resident's family did not receive an invitation to attend the care plan meeting.</p> <p>On 3/3/15 at 4:11 PM, administrative nursing staff B, reported the initial care plan meeting did not usually include the family.</p> <p>The undated facility policy for Comprehensive care plans included the IDT (interdisciplinary team) in conjunction with the resident, the resident's family or representative, as appropriate, will meet within the first 7-14 days of admission to help develop a care plan.</p> <p>The facility failed to invite the resident and/or their family in the initial care plan meeting, to assist in the development of the care plan to meet the resident's physical and psychosocial needs.</p>	F 280			
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 9</p> <p>This Requirement is not met as evidenced by: The facility had a census of 27 resident's, with 2 reviewed for urinary incontinence. Based on observation, interview and record review, the facility failed to provide an individualized toileting program to promote urinary continence for the 2 (#36 and #20) residents sampled.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident (#36) admitted on 11/22/14, with the following diagnoses dementia (progressive mental disorder characterized by failing memory, confusion), Cerebrovascular accident (CVA- the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), and depression, (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) obtained from the Physician's Order Sheet dated 2/24/15.</li> </ul> <p>The admission MDS (minimum data set), dated on 11/28/14, revealed the resident had long term and short term memory problems and with cognition severely impaired. The resident was frequently incontinent of bladder and required extensive assist of 1 staff for toileting.</p> <p>The resident record lacked any CAA (care area assessment) for this resident.</p> <p>The quarterly MDS, dated on 2/17/15, revealed the resident's cognition remained severely impaired, without changes from the previous MDS assessment, dated 11/28/14.</p> <p>The plan of care, dated on 2/11/15, revealed the resident required hands on help for toileting and hygiene when incontinent. The resident had</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 10</p> <p>occasional incontinence of bladder related to dementia. The resident needed toileted after waking up, before and after meals, at HS (hour of sleep) and needed monitored through the night. The care plan also instrcted staff of the need to assess the residents bladder study for pattern and possible interventions.</p> <p>The urinary incontinence evaluation, undated, revealed the resident had a history of incontinence and UTI's (urinary tract infection), and was frequently incontinent on 7 or more episodes.</p> <p>The five day bowel and bladder toileting record, dated from 11/23/14 to 11/28/14, revealed the resident was incontinent 12 times, toileted and voided 42 times, and toileted without voiding 6 times in this 5 day assessment period.</p> <p>The Quarterly Summery Assessment, dated 2/17/15, documentated the resident was occasionally incontinent of bladder.</p> <p>Observation, on 3/2/15 at 11:30 AM, revealed the resident assisted to the bathroom by direct care staff K and L. The resident's incontinent brief was moderately saturated with urine.</p> <p>Observation on 3/2/15 at 12:45 PM, revealed direct care staff K took the resident to the bathroom when returned from lunch. The resident was not incontinent and voided in the toilet.</p> <p>Observation on 3/2/15, at 4:00 PM, revealed direct care staff K took the resident to the bathroom and removed a urine wet incontinent brief, prior to toileting.</p> <p>On 3/2/15 at 3:10 PM, direct care staff H, stated if</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 11</p> <p>the resident was incontinent, then staff would take the resident to the bathroom every 2 hours and if the resident was continent, the staff would offer to take them or remind them to go to the bathroom.</p> <p>On 3/4/15 at 11:43 AM, direct care staff O, stated the resident was frequently incontinent. The staff take him/her to the bathroom every 2 hours and PRN (as necessary). The resident does not have an individualized toileting program. When the resident was admitted, the staff completed a 5 day toileting diary. The staff take all of the residents that are incontinent to the bathroom every 2 hours and PRN.</p> <p>On 3/4/15 at 10:56 am, licensed nursing staff N, stated there was a bowel and bladder assessment that was done when admitted and annually and a 5 day voiding diary. The toileting schedule was every 2 hours and PRN if the resident were incontinent. There are no individualized voiding schedule for the residents.</p> <p>On 3/4/15 at 8:23 AM, administrative nursing staff A, stated when a resident was admitted the staff completed a 5 day incontinence diary and the nurse completed a incontinence questionnaire. The toileting program for the facility was every 2 hours for the day and evening shift, every 4 hours on the night shift. The residents do not have an individualized toileting program. The facility does not have a good toileting program. The MDS nurse will complete a bladder training assessment on admission and annually for bladder training potential. This was the policy that is in effect as of this time. According to the facility policy, we are not following the policy. The staff should be doing an individualized toileting plan for each resident, according to the 5 day</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 12 bladder diary and assessment.</p> <p>The facility undated, Bladder retraining policy, revealed the MDS coordinator will complete the bladder retraining assessment on admission, annually and PRN to evaluate for the bladder retaining potential. The purpose is to restore the resident's dignity and self respect. The staff are to take the resident to the toilet or commode every 2 hours on the 6:00 am to 2 PM shift, 2:00 PM to 10:00 PM shift, and every 4 hours on the 10:00 PM to 6: 00 am shift. The program will be evaluated weekly and a determination made to continue the retraining program or to discontinue. Document the findings on the bladder retraining progress notes or reevaluation notes on the reverse side of the bladder retraining assessment. incorporate the individual program in the nursing care plan.</p> <p>The facility failed to provide an individualized toileting program to promote urinary continence for this incontinent resident.</p> <p>- The physician order sheet, dated 01/16/15, revealed resident (#20), admitted on 8/30/14, with the diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), Cerebrovascular accident (CVA) (stroke) - the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and anxiety (a mental or emotional reaction characterized by</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 13 apprehension, uncertainty and irrational fear).</p> <p>The admission MDS (minimum data set), dated 9/10/14, revealed the resident had moderately impaired cognition and required extensive assist of 2 staff for toileting. The resident was occasionally incontinent of urine and received a diuretic medication on 7 days of the 7 day assessment period.</p> <p>The ADL (activities of daily living) functional status and rehabilitation CAA (care area assessment), dated 9/10/14, revealed the resident required extensive assist of 2 with toileting and transfers.</p> <p>The urinary incontinence CAA, dated 9/10/14, revealed the resident had occasional urinary incontinence.</p> <p>The quarterly MDS assessment, dated 11/26/14, revealed the residents cognition was intact. The resident required extensive assist of one person for toileting and was frequently incontinent of bladder.</p> <p>The plan of care, dated 12/31/14, revealed the resident had occasional urinary incontinence and instructed staff to toilet the resident upon rising, before and after all meals and at HS (hour of sleep). The resident required extensive assist for toileting.</p> <p>On 3/3/15 at 9:07 AM, direct staff O, stated the resident was incontinent half the time and continent half the time. The resident required 1-2 assist for transferring. The resident would sometimes let the staff know when he/she needed to go to the bathroom. The resident had a</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 14</p> <p>slow decline in continence, and the staff took the resident to the bathroom every 2 hours and PRN (as needed).</p> <p>On 3/3/15 at 4:15 PM, direct care staff I, stated the resident was frequently incontinent from admission until he/she discharged to another facility on 2/4/15. The resident had a small decline in continence from admission to discharge.</p> <p>On 3/4/15 at 8:23 AM, administrative nursing staff A, stated when a resident is admitted the staff do a 5 day incontinence diary and the nurse fills out an incontinence questionnaire. The toileting program is every 2 hours for the day and evening shift and every 4 hours on the night shift. Even with the 5 day diary the residents do not have an individualized toileting program. The facility does not have a good toileting program. The MDS nurse will complete a bladder training assessment on admission and annually for bladder training potential, which is the policy that is in effect as of this time. The facility was not following the policy. We should be doing a individualized for each resident according to the 5 day bladder diary and assessment. Staff A stated the resident was frequently incontinent.</p> <p>The facility's, undated, Bladder Retraining policy, documented the MDS coordinator will complete the bladder retraining assessment on admission, annually and PRN to evaluate for the bladder retaining potential. The purpose is to restore the resident's dignity and self respect. take the resident to the toilet or commode every 2 hours on the 6:00 am to 2 PM shift, 2:00 PM to 10:00 PM shift, and every 4 hours on the 10:00 PM to 6:00 am shift. The program will be evaluated</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 15 weekly and a determination made to continue the retraining program or to discontinue. Document the findings on the bladder retraining progress notes or reevaluation notes on the reverse side of the bladder retraining assessment. incorporate the individual program in the nursing care plan.  The facility failed to provide an individualized toileting program to promote urinary continence for this resident with urinary incontinence.	F 315			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This Requirement is not met as evidenced by: The facility reported a census of 27 residents. The 18 residents selected for sample review, included 4 residents for accidents. Based on observation, interview, and record review, the facility failed to ensure 1 resident (#32) received adequate supervision and/or assistive devices to prevent further falls, and 1 resident (#22) remained free of accident hazards which caused repeated bruising. Furthermore, the facility identified 7 residents at risk for elopement. The facility failed to ensure exit door alarms audible to the extent to alert staff and prevent residents from leaving the facility without staff knowledge.  Findings included:  - Observations, on 2/26/15 at 6:30 AM, revealed	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 16</p> <p>concerns with the facility 3 exit doors, which included the west hall exit, the east hall exit, and the dinette room exit. These concerns included;</p> <p>1.) From the far 1/2 of the west hallway, extending to the exit door, you could not hear the alarm sound, when the east hall exit and/or the dinette room exit doors opened and the alarm sounded.</p> <p>2.) From the far 1/2 of the east hallway, extending to the exit door, you could not hear the alarm sound, when the west hall exit and/or the dinette room exit doors opened and the alarm sounded.</p> <p>3.) From the far 1/2 of the dinette room, extending to the exit door, you could not hear the alarm sound, when the west hall exit and/or the east hall exit doors opened and the alarm sounded.</p> <p>At that time, further investigation revealed the facility exit door alarms from these 3 exit doors only sounded from 1 speaker, which was positioned near the nurses station area. During that time, questioning related to how the staff heard the exit door alarms, direct care staff M, reported, the alarms could be heard near the nursing area and in the break room (which is close to the nursing station). Staff M did not recall how long the alarms were only heard in these areas.</p> <p>Interview, on 2/26/15 at 3:10 PM, with administrative nursing staff A, identified 7 residents as elopement risk, when the lack of audible exit door alarms were reviewed with staff A. Staff A reported being unaware of the staff not hearing the alarms in the resident rooms or some</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 17</p> <p>other areas of the facility, until the facility staff were questioned by the survey team. The staff member lacked awareness of how long the alarm had not been audible, but verified the audible problem with the alarms.</p> <p>The facility failed to maintain an audible exit door alarm system in place to ensure the safety of the 7 residents, identified as elopement risk.</p> <p>- Resident # 32's admission MDS (minimum data set) assessment, dated 2/3/15, identified the resident with severely impaired cognition, long and short term memory impairment, and with modified impairment for decision making skills. The assessment identified the resident required extensive assistance of 1 staff for ADL's (activities of daily living) of transfers and walking. Additionally, the resident had unsteady balance, no ROM (range of motion) impairment, used a walker, and experienced a fall history with 1 fall since admission.</p> <p>The 2/3/15 Care Area Assessment for falls identified the resident at risk for falls related to a fall at home, and a lack of safety awareness.</p> <p>The fall risk assessments, identified the resident at high risk for falls on 2/3/15 with a score of 18, and on 2/1/15 with a score of 20. The assessment indicated a score of 10 or greater indicated a high risk for falls.</p> <p>The resident's 2/9/15 care plan instructed staff:</p> <ol style="list-style-type: none"> <li>1. Ensure the use of walker when walking.</li> <li>2. Ensure shoes or non-skid socks on.</li> </ol>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 18</p> <p>3. Supervision when up and about and usually required one assist with all cares and cues when walking.</p> <p>4. Monitor for any changes in balance.</p> <p>5. Keep room free of clutter.</p> <p>6. On 2/10/15, the latest intervention included PT (physical therapy) to evaluate the resident for wheeled walker safety.</p> <p>The physician orders, dated 2/3/15, an order for a PT evaluation related to safety. Additional review of the clinical record lacked results of the evaluation by the PT.</p> <p>Review of nursing notes, for a fall, which occurred on 2/1/15, included documentation at 11:10 AM, that the resident fell in the commons area. The documentation further identified the staff observed the resident had the rolling walker too far out in front of the him/her, which caused the resident to sit down on his/her bottom. The documentation further noted a request from the physician for a PT evaluation for safety with the use of the rolling walker, as the intervention to prevent another fall.</p> <p>On 3/2/15 at 11:15 AM, direct care staff E, used a gait belt on the resident and a 4 wheel rolling walker, to assist the resident. Staff E reported the resident more confused at times than others and needed cueing for ADL 's, with some assistance.</p> <p>On 3/2/15 at 9:00 PM, the resident rested in bed, with a ¼ rail on 1 side of the bed in the raised position, and the rolling walker at the bedside.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 19</p> <p>On 3/3/15 at 7:15 AM, the resident ambulated with the use of a rolling walker, a gait belt and staff assistance, to the dining table.</p> <p>On 3/3/15 at 11:20 AM, direct care staff E, reported they were unaware of any falls by the resident, but believed all residents should have a gait belt used on them, with the residents requiring assistance of staff. The staff believed the resident continued to use the same walker for the past several weeks and was not aware of any physical therapy evaluation.</p> <p>On 3/3/15 at 2:01 PM, direct care staff F reported he/she lacked awareness of the resident experiencing any falls, and/or any changes in the resident 's plan of care.</p> <p>Licensed nursing staff C reported on 3/3/15 at 2:56 PM, the resident received orders on 2/3/15, following a fall on 2/1/15, for a physical therapy evaluation related to safety with the use of the resident 's rolling walker. The staff further reported the resident did not receive the physical therapy evaluation until 2/20/15. Staff C further indicated the facility lacked any recommendations from the evaluation, as of that time. Furthermore, staff C reported the staff failed to implement an immediate intervention, to prevent another fall, from 2/1/15 to 2/20/15, (19 days) to ensure the resident's safe ambulation.</p> <p>On 3/4/15 at 10:29 AM, administrative nursing staff A reported the resident was seen at the therapy department at the hospital as soon as the hospital could schedule the patient. Staff A indicated the staff should have implemented an immediate intervention as well, due to the lack of timely scheduling for the outside therapy services.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 20</p> <p>An 11/09 Fall Incident Policy included to assess for the cause of the incident. This is essential to determine the cause and to provide appropriate interventions. An intervention is required for all falls and skin incidents.</p> <p>The facility failed to implement interventions, in a timely manner, to prevent repeated falls, after the resident experienced a fall.</p> <p>- Resident #22's physicians order sheet, dated 1/14/15, included the diagnoses of Alzheimer's dementia (a progressive mental deterioration characterized by confusion and memory failure).</p> <p>The quarterly MDS (Minimum Data Set), dated 2/18/15, revealed a BIMS (Brief Interview for Mental Status) score of 10, which identified the resident as moderately impaired cognitively. The resident required supervision for bed mobility, transfers, walking, locomotion, and toilet use.</p> <p>The Care Area Assessment, dated 11/26/14, revealed:</p> <p>Cognitive Loss section included the resident had Alzheimer's dementia and had daily confusion. The resident needed supervision and redirection to where he/she was to go and what he/she was to do. He/she did repeat questions at times.</p> <p>ADL (Activities of Daily Living) included the resident was independent with walker but did require cues and supervision. He/she had Alzheimer's and was confused daily and needed cues and supervision and at times needed hands on care to complete daily tasks to be clean, dry, and safe.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 21</p> <p>The care plan, reviewed 2/18/15, directed staff that the resident was incontinent of urine occasionally and he/she did walk fast at times and may go around corners sharply and risk injuring himself/herself. The staff were to remind the resident to slow down and to be careful when going through doorways and turning corners. Nurse to perform weekly skin assessment. Staff were to be alert for any bruising especially to the resident's back, hands, and torso.</p> <p>The weekly skin integrity review, dated 12/16/14, documented licensed staff noted old bruising to both anterior forearms. On 1/4/15 and 1/11/15, licensed staff noted old bruising, but lacked any notation of a specific location. On 1/18/15, 1/27/15, 2/1/14, 2/15/15, licensed staff noted fading bruising to insulin injection sites.</p> <p>The weekly shower skin assessments, dated 12/4/14, documented direct care staff noted purple bruises to the resident's posterior right and left forearms. On 12/22/14, direct care staff noted bruises to the anterior portion of both of the resident's forearms. On 1/1/15, direct care staff noted bruising to the resident's anterior of both forearms. On 1/22/15, direct care staff noted bruising to the resident's posterior left arm, in 2 areas, and posterior left hand. On 2/23/15, direct care staff noted scattered fading bruises to the resident's forearms, with areas indicated on the right anterior forearm, left anterior forearm and left shoulder area.</p> <p>Observation, on 3/2/15 at 9:56 AM, revealed the resident's arms contained four bruises, approximately 1/2 inch each, to his/her right forearm, that were equally spaced about 3 inches apart, and one bruise, about 1 by 2 inch, to his/her left elbow. The resident denied any pain</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 22</p> <p>or discomfort with the bruising, and stated that he/she may get them from bumping up against things. The resident wore a short sleeve T-shirt, without any protective garments on the resident's arms.</p> <p>On 3/3/15 at 2:10 PM, direct care staff O reported that in the past the resident had problems bumping into things, but he/she was doing better now. Staff O stated, he/she was not aware of any current bruises. Direct care staff I added the staff would report any bruises to the charge nurse and the nurses should measure the size and document them. Staff O then added that the resident does get some bruises to his/her abdomen (stomach area) from injections (shots). Staff O confirmed the resident had, at that time, some discolorations on his/her hands and arms that have been there for years.</p> <p>On 3/3/15 at 3:48 PM, direct care staff F reported the resident did not have any problems getting around by himself/herself. Staff F added, if any bruising is seen, he/she would document the bruises on the shower sheet and tell the charge nurse so it could be documented. Staff F stated the resident was currently without any bruising.</p> <p>On 3/4/15 at 11:15 AM, licensed nursing staff N confirmed the current bruising to the resident's forearms. The resident wore a short sleeve T-shirt, without any protective garments on the resident's arms. Staff N reported that direct care staff would notify licensed staff if there are any concerns of bruising. Staff N confirmed the resident did have issues with bruising due to bumping into objects with transfers. Monitoring for bruising included the weekly skin assessments completed by the nurses. Follow-up included that the bruising was fading. Staff N then</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 23</p> <p>went into the resident's room and felt the side rail and stated that the resident might have bumped the rail in the night. Staff N confirmed the facility lacked any investigation related to the cause of the bruises at that time.</p> <p>On 3/4/15 at 11:25 AM, administrative nursing staff A reported the facility protocol required any new bruising observed on residents be brought to his/her attention, so he/she could try to determine the cause and initiate appropriate interventions to prevent further bruising. Staff A confirmed the current four bruises to the resident's left forearm, and stated that he/she was not made aware of these bruises, and therefore did assess the cause. Observation, of the resident, at that time, revealed the resident remained in a short sleeve T-shirt, without any protective garments on the resident's arms</p> <p>The facility's, 11/09 Fall Incident Policy, included to assess the resident for the cause of the incident. This is essential to determine the cause and to provide appropriate interventions. An intervention is required for all falls and skin incidents.</p> <p>The facility failed to assess the cause of this resident's bruises and implement interventions to prevent repeated bruises from accidents and/or environmental hazards.</p>	F 323			
F 327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This Requirement is not met as evidenced by:</p>	F 327			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 327	<p>Continued From page 24</p> <p>The facility reported a census of 27 residents. The sample size included 18 residents, with 1 person reviewed for hydration. Based on observations, interview, and record review, the facility failed to provide 1 resident (#19) sufficient fluid intake to maintain proper health.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #19's Physician Orders Sheet ,dated 1/21/15, listed the diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion).</li> </ul> <p>The resident's annual MDS (Minimum Data Set), dated 1/7/15, revealed the resident was severely impaired cognitively. The resident required supervision with set-up assistance for eating; and extensive assistance for bed mobility, and transfer. No nutritional approach identified while a resident. Dehydration was not identified.</p> <p>The Cognitive Loss CAA (Care Area Assessment), dated 1/12/15, included the resident continued to slowly decline due to his/her dementia. He/She was able to answer questions when asked on day of assessment but had days when he/she was very drowsy and slept the majority of day.</p> <p>The Functional Status CAA, dated 1/12/15, included the resident no longer walks and is a two person assist with position changes. The resident fed himself/herself with frequent cuing. At times staff must feed him/her.</p> <p>The resident ' s care plan, reviewed 1/14/15, directed staff to provide assistance with meals, set-up, cut up food, and observe, related to the resident sometimes just sits there. Staff are to</p>	F 327			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 327	<p>Continued From page 25</p> <p>cue the resident as needed, and physically help as needed, if he/she is agreeable to receiving assistance. Furthermore, the care plan identified that the resident had days he/she was awake and very talkative then he/she was asleep majority of the day. This can last for a few days then the resident crashes and becomes lethargic. Support and monitor the resident for eating and drinking. Offer preferred food/ fluid items. Offer fluids when in room assisting with cares and off of snack cart. Dietician to assess as needed.</p> <p>The Daily Food Consumption Record, from 1/1/15 to 1/7/15, revealed the resident consumed 480 cc (cubic centimeters) - 980 cc of fluids daily.</p> <p>The Nutrition Risk Assessment, dated 1/7/15, signed by consultant staff X, revealed the resident required a total of fluids per day of 1665 cc. Furthermore, staff listed the oral nutrition intake- fluid as high risk, whereas the resident consumed less than 1000 cc per day with meals.</p> <p>The dietary note, dated 2/11/15, revealed the resident ate at the restorative dining table. The resident took some snacks and drinks from the snack cart, and to continue with the current plan of care.</p> <p>On 2/26/15 at 10:35 AM, an observation revealed the resident's mouth was dry. The resident confirmed that his/her mouth was dry. A supplement shake, 2 glasses of water, and a water pitcher sat on the bedside table, out of the resident's reach. The resident bed was in a low position, and the fluids were above him/her and out of reach.</p> <p>On 3/2/15 at 9:45 AM, the resident rested in bed, snoring with his/her dentures dislodged and dry.</p>	F 327			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 327	<p>Continued From page 26</p> <p>The water pitcher and a small glass of water sat on the bedside table, out of the reach of the resident. At 10:20 AM, the resident sat in the wheel chair, in the group exercises, with a cup with aluminum foil on the top. At 11:32 AM, one hour and 12 minutes later, the resident remained in the wheel chair in the front room at the table with the same drink in his/her hand, which 1/4 of the drink remained.</p> <p>On 3/2/15 at 3:31 PM, the resident rested in bed with her eyes closed. The resident's water pitcher remained on the bedside table with the same noted volume of water in it, when noted at 9:45 AM. The water pitcher sat on the end table, with the lid closed and a glass of water on the table out of the resident's reach. At 3:36 PM, direct care staff K took the resident a 2-Cal (high protein) shake. Staff K raised the head of the bed, gave the resident some of the shake, washed his/her mouth, and then gave more of the shake. The resident's lips appeared dry, and continued to appear dry after the shake. Staff K reported the he/she washed the resident's mouth related to some previous food debris remained on his/her mouth. Staff K added the resident usually drinks all of the shake if he/she is up and moving, and the resident only consumed 75% of the shake ate that time. Staff failed to offer any other water to the resident at that time.</p> <p>On 3/3/15 at 7:32 AM, the resident rested with eyes closed, with his/her mouth open and breathing through his/her mouth. Direct care staff O rinsed and washed the resident's dentures and assisted to place them into the resident's mouth. The direct care staff O and I completed morning cares. The closed water pitcher (with 28 ounces) and approximately 1 inch of water in a glass remained on the bedside table. Staff failed to</p>	F 327			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 327	<p>Continued From page 27</p> <p>offer the resident any drinks of the water. Staff I reported this was the normal procedure for morning cares. Staff I reported he/she did not know what the resident drank this morning. At 8:38 AM, the resident consumed a total of 120 cc of orange juice for the meal related to the resident would not arouse. Direct care staff I and O toileted and transferred the resident to bed. The resident's eyes were open during the transfers to the toilet and then to his/her bed. Staff failed to offer any water or fluids. The same amount of the 28 ounces remained in the water pitcher, and approximately 1 inch of water in the glass.</p> <p>On 3/3/15 at 1:40 PM, direct care O reported the resident had days that he/she will drink really well, on other days staff had to encourage him/her. Staff O stated the resident received fluids at meals and snack times. Staff O stated the resident received a drink when they got him/her up that morning. Upon questioning of the fluids offered, staff O then confirmed he/she failed to offer the resident a drink.</p> <p>On 3/3/15 at 3:48 PM, direct care staff F reported the resident gets more tired and he/she needs more help for eating/drinking. The resident drinks fluids well, if awake enough. If the resident wants a drink, sometimes he/she was able to ask for a drink, but that day/ week the resident was pretty tired.</p> <p>On 3/4/15 at 9:39 AM, licensed nursing staff N reported cares included to offer drinks at meals, snacks, and the resident will verbalize if he/she needs a drink. Staff added there are days that the resident will not eat or drink, and staff should offer drinks when they work with him/her.</p>	F 327			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 327	<p>Continued From page 28</p> <p>On 3/4/15 10:25 AM, consultant staff X reported he/she identified the resident's hydration concern, and provided a note to staff, to increase the resident's fluid intake. The facility are assisting with fluids as per putting him/her at the restorative table.</p> <p>On 3/4/15 at 2:52 PM, administrative nursing staff T reported the resident's mouth was dry and this was related to he/she was a mouth breather. Administrative nursing staff A reported that fluids should be offered to the resident at meals, with medications, and offered at snack time. Staff A added every time the facility staff entered the resident's room, staff should offer the resident water.</p> <p>On 3/4/15 at 4:30 PM, administrative nursing staff A stated the facility lacked a policy related to hydration.</p> <p>The facility failed to provide this resident sufficient fluid intake after the consultant staff identified hydration as a concern for this resident.</p>	F 327			
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 29</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 27 residents, with 5 selected for review of unnecessary medications. Based on record review and interview, the facility failed to adequately monitor and document behaviors for 1 (#37) of the 5 residents reviewed related to antipsychotic use.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident (#37) was admitted on 12/23/14, with the diagnoses of senile dementia and psychosis, obtained from the Physician's Order Sheet, dated 2/23/14.</li> </ul> <p>The admission MDS (minimum data set), dated 12/29/14, revealed the resident had a BIMS (brief interview of mental status) score of 11, indicating the resident had moderately impaired cognition. The resident had no behaviors identified. The resident received an antipsychotic for 7 days of the 7 day assessment period.</p> <p>The cognitive loss CAA (care area assessment), on 1/5/15, revealed the resident was confused at times and had some short term memory deficits.</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 30</p> <p>He/She had a diagnosis of dementia. The resident needed reminders as to meal times and staff takes him/her to and from meals usually.</p> <p>The psychotropic drug CAA, on 1/5/15, revealed the resident received zyprexa daily and staff needed to be alert for any sign or symptoms of adverse affects to the medication. The resident was at a geriatric psychatric hospital and had a diagnosis of dementia with delirium but had shown no signs or symptoms of delirium since admission.</p> <p>The plan of care, dated 1/15/15, revealed the resident had some issues with remembering things and being confused at times. The resident needed cued and reminded about tasks and upcoming events. The resident has dementia and had issues with wandering in the past and needed to be monitored for any changes in his/her behavior. The resident was on an antipsychotic medication and was at risk for adverse affects to medication. The plan of care failed to address the concern (delerium) for which the resdient recieved the antipsychotic medicaiton.</p> <p>The admission physican order sheet, dated 12/23/14, revealed an order for Zyprexa 2.5 mg by mouth, twice a day for psychosis.</p> <p>The Physician order sheet, dated on 2/23/15, revealed an order on 2/13/14 to decrease Zyprexia (antipsychotic) to 2.5 mg, give by mouth daily for psychosis.</p> <p>The physician fax communication, on 2/20/15, revealed the resident continued on zyprexa 2.5 mg with no negative behaviors, after it was decreased from 5 mg. The physician ordered to</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 31 discontinue the zyprexa.</p> <p>The residents clinical record lacked any behavior logs for monitoring of the antipsychotic medication from 12/23/14 to 2/20/15.</p> <p>On 3/4/15 on 12:10 PM, administrative nursing staff A, stated the resident only had behaviors prior to admission and the report that was obtained from the geri psych hospital, was that the resident had not had any behaviors at the hospital. Staff A stated he/she would not have known what behaviors to put on the behavior sheet for the resident. When the facility started the gradual dose reduction of the antipsychotic, staff A reported verbally to the pharmacist and the physician about the resident's condition. Staff A stated that now that he/she looks back, he/she should probably have had the staff chart in the behavior logs for this resident.</p> <p>On 3/4/15 at 1:04 PM, consultant staff X stated when looking at antipsychotic medications, he/she would look at the behavior sheets and the nurses notes when considering the resident for gradual dose reduction. He/She did not remember if he/she had seen behavior logs for this resident or not.</p> <p>The psychotropic drug use policy, undated, revealed the physician's order for a psychotropic drug would include both a qualifying diagnosis for the drug and a list of specific target behaviors which the staff would monitor during the drug administration. The noting nurse would be responsible for initiating a behavior monitoring process based on the qualifying diagnosis and the specific target behaviors for each drug, each drug will require a separate monitoring form including specific target behaviors for each</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 32 specific drug.  The facility failed to ensure this resident remained free of unnecessary medications related to failure to consistently monitor the resident for behaviors related to the administration of the Zyprexa (an antipsychotic medication).	F 329			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 33</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on record review and interview, the facility failed to maintain an infection control program to track, trend and analyze the infections in the facility, to prevent the spread of infection to the residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Review of the Infection Control Log, on 2/26/15 at 4:30 PM, included the following data concerning infections:</li> </ul> <p>March 2014- 2 UTI's (urinary tract infections), 1 skin infection, and 1 shingle outbreak.</p> <p>April 2014- 3 UTI's, 1 wound, 1 URI (upper respiratory infection), and 1 pneumonia infection.</p> <p>May 2014- 3 UTI's, 1 wound, 1 URI, 1 bronchitis, and 1 pneumonia infection.</p> <p>June 2014- 10 URI's and 2 pneumonia infections.</p> <p>July 2014- 1 UTI.</p> <p>August 2014-none.</p> <p>September 2014-5 UTI's and 1 cellulitis.</p> <p>October 2014- 6 UTI's, 1 URI, and 1 wound.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E473</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>COFFEY COUNTY HOSPITAL LTCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>128 S PEARSON AVE WAVERLY, KS 66871</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 34</p> <p>November 2014- 2 UTI's, 2 cellulitis, and 1 diverticulitis.</p> <p>December 2014- 6 UTI's.</p> <p>January 2015- 4 URI's and 1 skin.</p> <p>Interview, on 3/3/14 at 2:25 PM, with administrative nursing staff A, reported the facility failed to track/trend the cultures, related to the noted infections. The staff failed to implement a system to monitor the results of the cultures upon receipt, when the physician ordered the start of antibiotics prior to the culture results, to ensure appropriate antibiotics for the residents of the facility.</p> <p>The facility failed to review, track, and/or trend the cultures of infections, when identified, to ensure the antibiotic medications ordered and administered, adequately treated the infections of the residents.</p>	F 441			